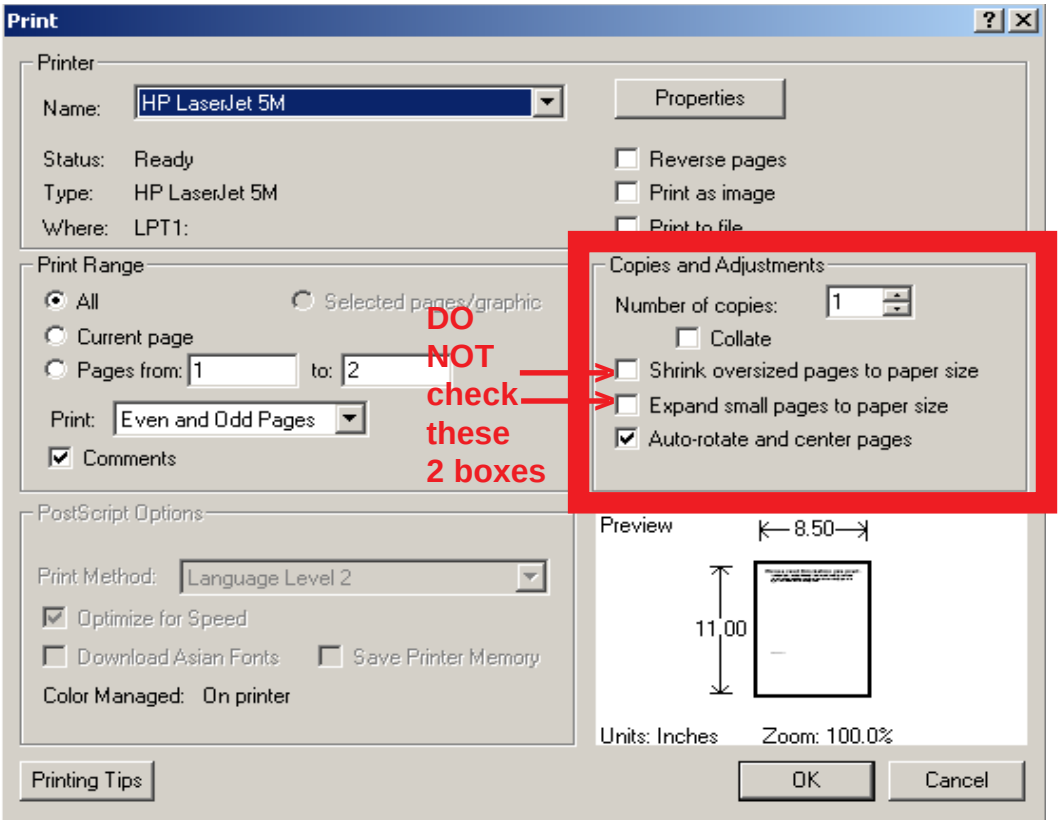
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



DOH 600-033 (2/2004)

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents: Health Care Facility and Health Care Practitioner Credential Application Packet

1. 684-012 ..... Contents List/SSN Information/Deposit Slip ..... 1 page
2. Memo to Health Care Facility and Health Care Practitioner ..... 1 page
3. 684-015 ..... Health Care Assistant Certification—General Information ..... 1 page
4. 684-016 ..... Application Instructions for Health Care Assistant Certification ..... 2 pages
5. 684-002 ..... Application for Certification as a Health Care Assistant ..... 6 pages
6. 684-017 ..... Important Information Regarding Personal Data Questions ..... 1 page
7. 684-018 ..... Health Care Assistant Certification—Education Requirement ..... 1 page
8. 684-019 ..... Health Care Assistant Certification—Category G—To Perform Hemodialysis ..... 1 page

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Health Care Facility / Practitioner DEPOSIT SLIP

DOH 684-012 (REV 10/2003)

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

1F 0252150000 00241

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STATE OF WASHINGTON

DEPARTMENT OF HEALTH

HEALTH PROFESSIONS QUALITY ASSURANCE

To: Health Care Facility And Health Care Practitioner

From: Tracy Hansen, Program Manager
Health Care Assistant Program

Subject: **The Credentialing of Health Care Assistants**

Washington State requires certification of all unlicensed individuals who may be administering skin tests, subcutaneous, intradermal, intramuscular, and intravenous injections, perform minor invasive procedures to withdraw blood and/or hemodialysis in this state.

Attached is an application packet for health care assistant certification. The application packet includes: application form, application instructions, personal data questions, general information, education requirements, and hemodialysis. Please have the applicant review the entire application packet prior to completing the application form. When the applicant signs and dates Section 9. Applicant's Attestation, of the application form, the applicant is attesting to the Department of Health that they have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that they answered all questions truthfully and completely and the documentation provided in support of their application is, to the best of their knowledge, accurate.

The application form with original signatures and dates, fee and required documentation should be submitted together to the Department of Health.

The Department of Health, Health Care Assistant Program will provide technical assistance to any person who needs assistance in filling out the health care assistant application form and/or needs clarification of the statute, rules, requirements, and processes for health care assistant certification.

The Health Care Assistant Program staff may be reached at (360) 236-4942.

Washington State Department of Health
Health Professional Quality Assurance
PO Box 1099
Olympia WA 98507-1099

Health Care Assistant Certification

General Information

Issuance of Health Care Assistant Certification:
Health care assistant certification is issued to the health care facility or health care practitioner authorizing the health care assistant to perform the specific category(ies). The certification is issued for two years from the date of issuance.

Renewal of Health Care Assistant Certification:
Renewal notice and Health Care Assistant Renewal Affidavit form are mailed to the health care facility or health care practitioner approximately 45 days prior to the certification expiration date.

The Department of Health requires original signature and date of both the health care assistant and delegator on the renewal affidavit form. Please complete the form in its entirety.

Please submit the renewal notice, renewal affidavit and renewal fee of $60.00, in check or money order made payable to the Department of Health, to the Customer Services Center.

Late Renewal Fee:
A late penalty fee of $50.00 will be charged to those individuals who do not submit payment to the Department of Health of the health care assistant certification renewal fee on or before the expiration date of their certification.

Recertification:
A change of health care facility or health care practitioner, and/or category requires a new application, recertification fee of $60.00, and supporting documentation.

Delegator Change and Address Change:
Delegator and address changes (within the same facility) may be made at any time by submitting the request for change in writing to the Customer Services Center.

Duplicate Certification:
Duplicate certification may be made at any time by submitting the request in writing to the Customer Services Center, along with a duplicate fee $15.00, in check or money order made payable to the Department of Health. Please identify the name of the health care assistant, certification number, and provide the current health care facility or health care practitioner mailing address and telephone number.

DOH Health Care Assistant Web Site:
The HCA application packet, application for expired credential packet and statute and rules are available on the Department of Health Website: https://fortress.wa.gov/doh/hpqa1/hps7/Health_Care/default.htm.

Customer Services Center:
The Department of Health, Customer Services Center, is responsible for all health care related application packet and law book requests, verification of credentials and processing of all renewals. You may contact the Customer Services Center at:

Department of Health
Customer Services Center
PO Box 47865
Olympia WA 98504-7865

Telephone (360) 236-4700
Fax (360) 236-4818
Email: doh.hpqa.csc@doh.wa.gov

Washington State Department of Health
Health Professional Quality Assurance
PO Box 1099
Olympia WA 98507-1099

Application Instructions For Health Care Assistant Certification

Application Fee **$60.00**

Check or money order may be made payable to the Department of Health

All Fees Are Non-Refundable

Send the application and fee to:

Department of Health
Health Care Assistant Program
PO Box 1099
Olympia WA 98507-1099

If you are sending **supporting documents** separate from the six page application form, please mail supporting documents to the following address:

Department of Health
Health Care Assistant Program
PO Box 47869
Olympia WA 98504-7869

(360) 236-4942

(360) 236-2406 Fax

Please review and follow the instructions carefully so that the application may be processed promptly. **The application form with original signatures and dates, fee and required documentation should all be submitted together to the Department of Health**. Applications are not considered complete until all supporting documents are received and the appropriate fee has been paid. It is the applicant's responsibility to provide clear and sufficient documentation. The application review process is approximately two weeks. Applicants are discouraged from calling to check on the status of an application until receipt of this acknowledgment. Your cooperation is requested to permit program staff to prepare your file and issue your certification at the earliest possible time.

To assure appropriate review, all information should be typed or printed clearly throughout the entire application form except for the signature lines.

1. Demographic Information

Complete all applicant and delegator information. Choice of delegator: MD, DO, DPM, ARNP/PR Authority or ND who is licensed in Washington State.

2. Category(ies) Under Which Applicant Is Certified And Authorized To Perform

Please select the appropriate category(ies) for which the delegator is authorizing the applicant to be certified to perform. Please Note: Intra-arterial injections are not authorized under Health Care Assistant law.

3. Personal Data Questions

The applicant must answer the personal data questions as required by chapter 18.135 RCW. If any question on the personal data page has a **"Yes"** response, **please provide a letter of explanation.** For questions 5 through 9, if the applicant answers **"Yes"**, **please include with a letter of explanation, copies of all judgments, decisions, orders, agreements and surrenders**. Failure to respond to the questions will delay the processing of your application.

Please Note: The Department of Health conducts routine criminal background checks on all applications prior to review for credentialing.

4. Professional Training And Experience

A resume will **not** substitute for completion of the application. Please use the initials **N/A** (not applicable) if the applicant has not had professional training and experience.

If the applicant checks Categories B, C, D, E and/or F on the application form, copies of transcripts that indicate completion for required courses for categories B, C, D, E and/or F are needed in order to process the application. Verification of the following classes: anatomy, physiology, basic pharmacology, pharmacological principles and medication administration, mathematics, chemistry, concepts of asepsis and microbiology must be included.

NOTE: If the applicant's transcripts do not clearly identify that he/she has taken all of the above courses, and he/she has completed them, please provide a written statement identifying which classes in the applicant's transcript/course outline covered those subject.

5. Aids Education And Training Attestation

The applicant may sign and attest to having completed a minimum of seven (7) hours in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality and the psychosocial issues to include special population considerations.

6. Hemodialysis Technician—Category G

The Preceptor shall verify to the Department of Health that the applicant:

- completed six to eight weeks of training in both didactic and supervised clinical instruction, as required by WAC 246-826-302.
- meets the minimum standards of practice and core competencies of hemodialysis technicians as required by WAC 246-826-303.

The Preceptor must sign and date this section of the application form.

7. Medication And Diagnostic Agent List—Category(ies) C, D, E, F And/Or G

The applicant must complete the Medication and Diagnostic Agent List if he or she is applying for certification to be authorized to perform Category(ies) C, D, E, F and/or G. This applies to those procedures for injections and/or IV medications. Please indicate the specific medication and via the route. The applicant and the delegator are required to sign the Medication and Diagnostic Agent List.

8. Delegation Of Procedures

The delegator must sign the Delegation of Procedures section authorizing the applicant to perform those procedures identified in the category(ies) being requested for certification. The delegator also certifies that the health care assistant has met the required educational, clinical training and instructions, work experience, and has demonstrated the knowledge and skills.

9. Applicant Attestation

After the applicant has familiarized themselves with the statutes and rules cited in the law book, please sign and date the attestation.

Washington State Department of Health
Health Professions Quality Assurance
Health Care Assistant Certification Section
P.O. Box 1099
Olympia, WA 98507-1099

For Office Use Only	
CERTIFICATION #:	DATE ISSUED:
CANDIDATE #:	

CERTIFICATION #

Application For Certification As A Health Care Assistant

Check only one: ☐ New Certification ☐ Recertification (change of employer and/or category)

Please Type or Print Clearly—Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

1. Demographic Information

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL

RESIDENTIAL ADDRESS

CITY	STATE	ZIP	COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)	RESIDENCE TELEPHONE	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW.)
		— —

GENDER	BIRTHDATE	PLACE OF BIRTH	MAIDEN NAME
☐ Female ☐ Male			

FACILITY/DELEGATOR NAME

FACILITY MAILING ADDRESS

CITY	STATE	ZIP	COUNTY

DELEGATOR IS (CHECK ONE): ☐ MD ☐ DO ☐ DPM ☐ ARNP / PR Authority ☐ ND

DELEGATOR'S NAME

DELEGATOR LICENSE NUMBER	LICENSE EXPIRATION DATE

2. Categories Under Which Applicant Is Certified And Authorized To Perform

- ☐ A. Venous capillary invasive procedures for blood withdrawal.
- ☐ B. Arterial invasive procedures for blood withdrawal.
- ☐ C. The administration of skin tests and subcutaneous, intradermal, and intramuscular injections for diagnostic agents.
- ☐ D. Intravenous injections for diagnostic agents.
- ☐ E. The administration of skin tests and subcutaneous, intradermal, and intramuscular injections for therapeutic agents.
- ☐ F. Intravenous injections for therapeutic agents.
- ☐ G. Hemodialysis.

3. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☐

   b. a charge of a sex offense? ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

4. Professional Training And Experience

List in chronological order all professional education and experience including post secondary educational classes, college or university, technical or professional and practice pertaining to the profession for which you are making application. If applicable, include all periods of time from the date education was completed to present whether or not engaged in activities related to your practice as a health care assistant.

NAME AND LOCATION OF INSTITUTION, PLACE OF PRACTICE OR OTHER	DATES		DEGREE/CERTIFICATE AND DATE RECEIVED, NATURE OF EXPERIENCE OR SPECIALITY
	FROM (MO/YR)	TO (MO/YR)	

5. AIDS Education and Training Attestation

☐ School Curriculum

☐ Employer/Other

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my certification may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

6. Hemodialysis Technician—Category G Only

The hemodialysis technician, category G assistant shall receive training, evaluation(s), and assessment of knowledge skills to determine minimum level competency, as required by WAC 246-826-302.

I, _____
PRECEPTOR NAME—TYPE OR PRINT

(who supervises, trains, and/or observes student providing direct patient care in a dialysis facility or center)

verify that _____
HEMODIALYSIS TECHNICIAN—TYPE OR PRINT

completed six to eight weeks of training in both didactic and supervised clinical instruction, as required by WAC 246-826-302.

This individual meets the minimum standards of practice and core competencies of hemodialysis technicians as required by WAC 246-826-303.

(The dialysis facility may accept documentation of a hemodialysis technician's successful completion of training objectives in another dialysis facility or accredited academic institution if it is substantially equivalent to the core competencies described in WAC 246-826-303. The dialysis facility that accepts the documentation assumes responsibility for confirming the core competency of the hemodialysis technician.)

Signature of Preceptor _____ Date _____

7. Medication and Diagnostic Agent List—Categories C, D, E, F, and G only

This section must be completed in full for each health care assistant who gives injections or does IV therapy. The list is to be submitted with the initial registration and again with every recertification. If changes occur which alter the list of medication administration, a new list, properly signed, is to be submitted within 30 days.

Any changes of the medication list must be reported to the Department of Health within 30 days following the change. The Law Relating to Health Care Assistants 18.135 RCW authorizes invasive procedures only. Therefore, only those medications administered by injection should be listed. Please do not list oral, topical, rectal or inhalant medications.

Additional medication/diagnostic agents may be listed on additional pages

MEDICATIONS/DIAGNOSTIC AGENTS TO BE ADMINISTERED INCLUDE	VIA (ROUTE)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
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23	
24	
25	

DELEGATOR NAME (TYPE OR PRINT)

HEALTH CARE ASSISTANT NAME (TYPE OR PRINT)

SIGNATURE OF DELEGATOR

DATE

SIGNATURE OF HEALTH CARE ASSISTANT

DATE

8. Delegation of Procedures

I, _____,
DELEGATOR NAME—TYPE OR PRINT (MUST BE AN M.D., D.O., D.P.M., A.R.N.P. / PR AUTHORITY, OR N.D.)

verify that _____
HEALTH CARE ASSISTANT NAME—TYPE OR PRINT

may be delegated the authority to perform procedures applicable to the categories indicated. I attest that documentation of specific medications/diagnostic agents and routes of administration are authorized for this individual. Any alteration to the medication list will be provided to the Department of Health under my and the health care assistant's signatures within 30 days of the change.

I certify that the health care assistant has met the required educational, clinical training and instruction, and work experience applicable for the categories indicated.

I certify that appropriate supervision will be provided to the health care assistant in carrying out the procedures delegated by the health care practitioner.

Signature of Delegator _____ Date _____

9. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
Name of Applicant

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my certification to practice in the State of Washington.

Signature of Applicant _____ Date _____

Official Use Only

Washington State Records Center

Washington State Department of Health
Health Professional Quality Assurance
PO Box 1099
Olympia WA 98507-1099

Important Information Regarding

Personal Data Questions

This page contains important frequently asked questions and the Department of Health answers concerning the personal data questions. You will be held responsible for this information.

1. **For questions 5a, 5b and 5c, do I need to reveal a conviction that is over three years or over five years old?**

   Yes, this question asks if you have ever been convicted, etc. of any crime other than a minor traffic violation.

2. **For questions 5a, 5b and 5c, do I need to reveal a conviction that is not a felony?**

   Yes, you must reveal all convictions even if they were a misdemeanor or seem minor. The only exception to this is minor traffic infractions. You must, however, reveal a DUI or a Reckless Driving Conviction.

3. **What happens if I answer "no" to a question I should have answered "yes" to?**

   The Department of Health can issue a "Statement of Charges" against your application for certification based on a deceptive answer. You will have the chance to respond and, if necessary, go to a hearing regarding this matter. Be aware that this process can be quite lengthy.

   If you are granted a certification based on deceptive answers to the personal data questions and the Department later finds out about this, disciplinary action can be taken against your certification at that point in time. This means your credential could be revoked based on inaccurate information on your original application.

4. **Do I need to send documentation when I answer, "Yes" to questions 5, 6, 7, 8 or 9?**

   Yes, you must provide a signed and dated statement of explanation and copies of all judgments, decisions, orders, agreements or surrenders. If you do not send this documentation with your application, it will delay the processing of your application.

5. **What if I am convicted of a crime after I submit my application and/or received my certification?**

   You are required by RCW 18.130.070(4) to report any conviction, determination or finding that you have committed unprofessional conduct or are unable to practice with reasonable skill and safety.

Please contact the Department of Health at (360) 236-4942 if you do not understand the above information.

Mail completed application and fee to:

Department of Health
Health Care Assistants Program
PO Box 1099
Olympia WA 98507-1099

(360) 236-4942

Washington State Department of Health
Health Professional Quality Assurance
PO Box 1099
Olympia WA 98507-1099

Health Care Assistant Certification

Education Requirement

Washington Administrative Code, chapter 246-826, specifically, WAC 246-826-130 through WAC 246-826-180 identify categories A through F. Each category identifies the education, work experience and training required for the specific category.

The Department of Health requires a copy of transcript or diploma and course outline showing completion of the course information as outlined below. Please Note: If the applicant's transcripts do not clearly identify that he/she has taken all of the required courses, and he/she has completed them, please provide a written statement identifying which classes in the applicant's transcript/course outline covered those subjects, or the application will not be processed.

WAC 246-826-130 Category A minimum requirements.
Category A, to perform venous and capillary invasive procedures for blood withdrawal.
Education: High school education or its equivalent.
No additional education is required.

WAC 246-826-140 Category B minimum requirements.
Category B, to perform arterial invasive procedures for blood withdrawal.
Education: Minimum high school education or its equivalent with additional education to include but not be limited to anatomy, physiology, concepts of asepsis, and microbiology.

WAC 246-826-150 Category C minimum requirements.
Category C, to perform intradermal (including skin tests), subcutaneous, and intramuscular injections for diagnostic agents.
Education: One academic year of formal education at the post-secondary level. Education shall include but not be limited to anatomy, physiology, basic pharmacology, concepts of asepsis, and microbiology.

WAC 246-826-160 Category D minimum requirements.
Category D, to perform intravenous injections for diagnostic agents.
Education: Two academic years of formal education at the post-secondary level. Education shall include but not be limited to anatomy, physiology, basic pharmacology, mathematics, chemistry, concepts of asepsis, and microbiology.

WAC 246-826-170 Category E minimum requirements.
Category E, to perform intradermal (including skin tests), subcutaneous, and intramuscular injections for therapeutic agents.
Education: One academic year of formal education at the post-secondary level. Education shall include but not be limited to anatomy, physiology, pharmacological principles and medication administration, mathematics, concepts of asepsis, and microbiology.

WAC 246-826-180 Category F minimum requirements.
Category F, to perform intravenous injections for therapeutic agents.
Education: Two academic years of formal education at the post-secondary level. Education shall include but not be limited to anatomy, physiology, pharmacological principles and medication administration, mathematics, chemistry, concepts of asepsis, and microbiology.

Washington State Department of Health
Health Professional Quality Assurance
PO Box 1099
Olympia WA 98507-1099

Health Care Assistant Certification
Category G
To Perform Hemodialysis

Washington Administrative Code, chapter 246-826, specifically, WAC 246-826-301 through 303 identify category G, minimum requirements to perform hemodialysis, minimum training standards for mandatory hemodialysis technician training programs, and minimum standards of practice and core competencies of hemodialysis technicians.

The Department of Health requires verification from the Preceptor that the applicant:

- completed six to eight weeks of training in both didactic and supervised clinical instruction, as required by WAC 246-826-302.
- meets the minimum standards of practice and core competencies of hemodialysis technicians as required by WAC 246-826-303.

WAC 246-826-301 Hemodialysis technician, category G minimum requirements to perform hemodialysis.

WAC 246-826-302 Minimum training standards for mandatory hemodialysis technician training programs.

WAC 246-826-303 Minimum standards of practice and core competencies of hemodialysis technicians.